REPORT ON THE FUTURE ROLE OF MIDWIFERY IN MANITOBA

A joint statement by:

The College of Physicians and Surgeons of Manitoba
The Manitoba Association of Registered Nurses

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TABLE OF CONTENTS

Executive Summary ..... page i

Introduction ..... page iii

Definitions ..... page iv

Background ..... page 1

The Nurse-Midwife as a Specialty of Nursing ..... page 4

Scope of Practice ..... page 5

Qualifications ..... page 7

Standards of Competency ..... page 8

Liability Protection ..... page 8

Doctor/Midwife Relations ..... page 9

Specific Issues of Pediatric Care by Midwives ..... page 11

Economic Implications ..... page 12

Legislation ..... page 13

Future Direction & Recommendations ..... page 13

Appendix I - Home Births ..... page 16

Appendix II - Lay Midwives ..... page 18

Appendix III - Family Centered Care ..... page 19

Appendix IV - Isolated Settings ..... page 21

Appendix V - Acknowledgements ..... page 25

References ..... page 26

EXECUTIVE SUMMARY

The report of the joint committee on the future role of midwifery in Manitoba was forwarded by the College of Physicians and Surgeons of Manitoba and the Manitoba Association of Registered Nurses to the Minister of Health of Manitoba on February 28th, 1991. The report proposed the introduction of nurse-midwifery as an expanded service in Manitoba.

The leading recommendation was that a model program be established within which the role of the midwife can be further refined and the other recommendations can be evaluated prior to implementation.

The report includes recommending a time interval after which the academic/clinical preparation of the nurse-midwife would be post-baccalaureate. During this introductory period other credentials would be recognized and the skills of those with demonstrated abilities would be utilized.

Of the following recommendations, number one is the result of the overall deliberations of the Committee. Number two consists of specific observations and recommendations which are referenced to recommendations in the body of the report which bear the same numbers.

RECOMMENDATIONS:

1. Nurse-midwifery should be implemented in Manitoba. In order to facilitate this development, Manitoba Health should fund a developmental program during which the nurse-midwife will be employed. The Manitoba Association of Registered Nurses and the College of Physicians and Surgeons of Manitoba should be involved in the design and monitoring of the developmental program which must have:

   - clearly stated objectives;
   - comply with the elements of recommendation two;
   - include a concurrent evaluation system; and
   - have a stated implementation target date.

2. The following recommendations and statements should be used to guide the implementation of the developmental project.

   (I) The extension of authority for some medical acts to other members of the health team is necessary but will require careful implementation. Such extensions must be made with no loss of quality of outcome or service and mindful of issues relative to liability. The nurse-midwife must be prepared for and authorized to accept such responsibility.

   (II) Need has been identified for midwifery care among families in selected or "at risk" groups (teenage, aboriginal, core area, and immigrant families). Accordingly, a rural or selected "at risk" setting should be one element of the developmental program.

(III) The nurse-midwife is best positioned for the necessary team relationships which must be developed and is the only model which should be introduced into our health care team in Manitoba.

(IV) There is a role for the traditional birth attendant as specified in the activities defined in Appendix IV. There is no role for the lay midwife.

(V) Nurse-midwifery education provides the knowledge and skills required to provide a wide range of services to women and their families in a collaborative holistic approach. Specific responsibilities must be defined to ensure the provision and evaluation of these services in all components of reproductive care: antenatal, intrapartum, postpartrum, neonatal and designated gynaecologic needs.

(VI) A group of Manitoba nurse-midwives hold professional qualifications in midwifery from other jurisdictions. An enabling mechanism should be developed to allow these qualified individuals to practice within the Manitoba system. This provision should be available for a specified period of time and allow for necessary upgrading and credentialing of academic knowledge and clinical midwifery skills. A mechanism must be established to allow for nurse-midwives with acceptable out of province qualifications to be eligible to practice in Manitoba.

(VII) The Manitoba Association of Registered Nurses and College of Physicians and Surgeons should be charged with the responsibility for the delineation of entrance to practice qualifications, maintenance of standards of practice, and the provision of liability protection for nurse-midwives.

(VIII) The nature of coverage and cost impact of liability coverage must be discussed further with the relevant parties.

(IX) Many physicians have worked with or are interested in working with nurse-midwives in Canada. Various levels of participation by nurse-midwives, supervision by physicians and referral patterns between physicians and nurse-midwives and working relationships with other health care workers, have been proposed and variously accepted in other jurisdictions. Some examples of how these professionals might interact are presented in this paper for inclusion in the developmental program.

(X) In Manitoba midwifery as an insured service must be provided only by nurse-midwives who hold salaried positions. These salaries would be a direct "add-on" expense and must be accepted as such. The introduction of the nurse-midwife must have a parallel plan to evaluate potential areas of cost saving.

INTRODUCTION

In his letter of May 25th, 1990, The Honourable Donald Orchard, Minister of Health, asked the College of Physicians and Surgeons and the Manitoba Association of Registered Nurses (MARN) to

> *"... establish a cooperative working committee between the College of Physicians and Surgeons and the Manitoba Association of Registered Nurses, to prepare a Ministerial Consultation Paper defining a proposed role for midwives in the Province of Manitoba".*

A joint Task Force was created by the two bodies with the request that a report be provided by December 31st, 1990 (later by agreement with the Minister the date was extended to March 1st, 1991). The individuals appointed to the Task Force were:

- Dr. K. Brown, Chairman, and Registrar, College of Physicians and Surgeons
- Susan M. Derk, R.N., B.N., Co-chairman, and Executive Director, Manitoba Association of Registered Nurses
- Dr. J. Allardice, Director of Perinatal and Maternal Welfare Committee (PMWC)
- Dr. J. Carson, Pediatrician, Member of PMWC
- Annette Gupton, R.N., B.S., M.N., Associate Professor, University of Manitoba, School of Nursing
- Dr. M.J. Jamieson, Family Practitioner, Chairman, PMWC
- Kris Robinson, BScN., SCM

The Task Force has identified and worked toward the following goals:

1. Define the potential role of the midwife in Manitoba with specific reference to the professions of medicine and nursing.
2. Describe the implications for current legislation in order for this role to be introduced into Manitoba and define any additional regulatory requirements which may be required.
3. Define the qualifications which would be required of a nurse-midwife in Manitoba and define the educational program and credentials to be developed for future practitioners.
4. Define the scope of practice of the nurse-midwife in Manitoba.

In the course of their work, the Committee requested information from many individuals and agencies.

DEFINITIONS

1. Free standing birthing centers:

   A short stay, ambulatory, health care facility with a homelike environment and with prompt access to in-hospital obstetrical and newborn services designed to safely accommodate participating family members and support people of the woman's choice, and providing professional preventive health care to women and the fetus or newborn during pregnancy, birth and the puerperium.

2. Nurse-Midwife:

   A registered nurse who has completed a recognized educational program in midwifery, whose education and experience enable her to provide appropriate care and advice to women throughout their reproductive cycle, including pregnancy, labour, delivery and following birth.

3. Traditional Birth Attendant:

   A respected experienced woman in a community who have been recognized informally as someone to call on in time of need related to childbirth.

4. Companion:

   Can be husband or partner of parturient, mother of parturient, neighbour woman or some female support network. (From "Brought To Bed - Childbearing in America 1750 - 1950" by Judith Walzer Leavitt.)

5. Lay Midwife:

   A person, without recognized training, who offers services to child bearing families on a fee for service basis. The training may range from informal apprenticeship to a variable length of semiorganized training.

BACKGROUND

The World Health Organization (cited in Report of the Task Force On The Implementation of Midwifery in Ontario, 1987) defines a midwife as:

> *".....a person who, having been regularly admitted to a midwifery education program, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery."*

The midwife has achieved international acceptance as a health care professional who has obtained qualifications to care for the healthy pregnant woman. Despite this international recognition, midwifery, as described above, does not have legal status in Canada. In this country, midwifery services have been provided by physicians.

Over the past two hundred years the medical profession has gradually evolved the generalist (family physician) and the specialist (obstetrician). These professionals have served the needs of the pregnant woman very well and enabled Canada to maintain an enviable record of maternal/infant care despite the unique features of our geography and climate.

There is increasing awareness of the additional benefits which could result from the introduction of the midwife into the Canadian Health Team. In 1979, the Social Planning Council of Winnipeg in cooperation with the provincial Department of health and Community Services, established a Task Force to address the problems of unnecessary death, disease and handicap among pregnant women and infants in Manitoba. Their findings and recommendations published April, 1982, include the following observations which are even more relevant today:

> - *"...the Minister of Health should direct a more comprehensive approach to maternal and child health care. This approach is necessitated in part by a growing recognition that the aggregate health of Manitoba mothers and babies as measured by the perinatal mortality rate will only improve if preventive services are extended to high risk groups. In its review of services, the Task Force identified adolescents and native Indian women, working women and women living in the core area of Winnipeg or in rural and remote regions, as being particularly at risk. A more comprehensive approach with supportive community services is also necessitated by the mobility and economic stresses of our society and the increasingly frequent early discharge of new mothers and babies from maternity units."* (Author, p. viii)

- "Although many hospitals have instituted programs of Family-Centred Maternity Care, some have not. A critical component of family centred care is a team approach requiring the combined efforts of the woman and her family, health care providers and the community. Another aspect is respecting the parent's right to make informed choices about her care, within the limits of safety for mother and child and with the knowledge of the measures needed should risks develop. The Task Force's concern is that lack of receptiveness to consumer participation in the birth process may result in parents opting for less safe alternatives such as home birth." (Author, p. 39)

- "It has been stated that the postpartum period is the most vulnerable for the infant, for the beginning mother-child relationship, for the continuity of husband-wife relationship, and for survival of the family. This period offers the opportunity to deal with medical and social problems which may affect the course of future pregnancies, child development, or future family health. It is important that steps be taken to develop the support that is needed by the family to reduce the pressure and the potential for resultant difficulties such as child abuse, neglect or marital breakdown." (Author, p. 40)

In addition to needs which arise from our heritage and culture, Canada has experienced a growth in multiculturalism and the desire to have alternative choices in health care. The demand for midwifery services is expressed well in the September, 1988, midwifery report from the Manitoba Advisory Council on the Status of Women and in a letter from T. George (1988) Chairperson of the "Immigrant Women's Association of Manitoba, Inc.":

"1. As immigrant women most of us have come from countries where we or our own families have been the recipient of midwifery care during pregnancy, childbirth and post-childbirth (post-partum) and were very satisfied with the care we have received.

2. We see in midwife's care, there is continuity and less fragmentation, that is the pregnancy, labour, delivery and post-partum periods.

3. We see midwifery care, as much more encompassing in terms of family involvement, and the range of variables covered.

4. We see childbirth not just as a physiological process, but also a psychological and socio-

cultural experience for the women, her immediate and extended family. Hospital centred obstetrical care which is very much physiological oriented isolate the immigrant woman from her family and friends and often place her into a strange and threatening environment. The array of doctors, residents, labour and delivery nurses all are often ignorant of the immigrant childbearing woman's language and childbearing related cultural needs.

5. *We believe that properly prepared midwives will provide equal and often better care to the pregnant woman and her family than the obstetrical care presently available in Manitoba. We recommend that proper preparation of the midwives should take place at the post-registered nurse level."*

The recognized needs together with consumer demand for services place a strain on existing patterns of manpower. In a personal letter to the committee Dr. Philip F. Hall (1990) notes the diminishing supply of physicians available for reproductive care:

"There is a recognized tendency, as physicians age, to reduce the amount of obstetrics within their practice pattern. This reflects a larger trend to give up obstetric care, measurable in both Family Practitioners and Obstetrician/Gynaecologists.

As well, the number of physicians emerging from postgraduate programs in Obstetrics and Gynaecology is declining, as is the number who choose obstetrics as a part of their Family Practice training. In earlier stages of training, there has been a marked recent drop in the number of medical students who choose residencies in Obstetrics and Gynaecology. This was identified at the December 1989 meeting of the Canadian Association of Professors of Obstetrics and Gynaecology; where it was reported that record number of residency positions, (approximately 1/3 of those available) have been unmatched by the Canadian Intern Matching Service (C.I.M.S.) Residency Match process. In addition the proportion of non-Canadians and graduates of foreign medical schools continued to decrease as a result of current immigration policies and provincial limitations on employment. Maintenance of graduate training and resident output would require entry of more Canadian Medical School Graduates into Obstetrics and Gynaecology particularly as of 1991, and this is not taking place.

The proposed inclusion of midwifery is not meant to imply that midwifery is a "second best alternative." Such an individual if introduced to the Manitoba system might provide a capable and healthy alternative for the pregnant patient and her family with as much and in some cases more to offer than the "system" has offered up to this date. However, for this to be a success critical decisions must be made about responsibility, credentials, quality assurance and in particular medical/legal liability. If we recognize and address the conflicting values which have been evident in this area of health care, perhaps Manitoba has the potential of offering a capable and viable health care option as we approach the 21st century."

RECOMMENDATION (I): The extension of authority for some medical acts to other members of the health team is necessary but will require careful implementation. Such extensions must be made with no loss of quality of outcome or service and mindful of issues relative to liability. The nurse-midwife must be prepared and authorized to accept such responsibility.

RECOMMENDATION (II): Need has been identified for midwifery care among families in selected or "at risk" groups (teenage, aboriginal, core area, and immigrant families). Accordingly, a rural or selected "at risk" setting should be one element of the developmental program.

THE NURSE-MIDWIFE AS A SPECIALTY OF NURSING

Nursing education and practice in Canada is based on knowledge of physical, psychological and social sciences with specific emphasis on promotion of an individual's ability to function to maximum capability. Nurse-midwifery extends this basic preparation to include specific reference to reproductive care. There is a need for the traditional birth attendant in some jurisdictions, including Manitoba. (see Appendix IV)

The nurse-midwife employs a family centred approach to antenatal, intrapartum and postpartum care of mother and newborn. This philosophy of care would be employable in the small communities which are characteristic of Manitoba as well as urban settings. The nurse-midwife has the potential to reduce fragmentation of care by such an approach.

Midwifery is a specialty within the discipline of nursing parallel to the relationship of obstetrics to medicine. Nursing has well established, effective and cooperative relationships with other health professions, community services and consumer groups. The present nursing education system would require relatively little adjustment to prepare candidates for an expanded nurse-midwife role.

The existing effective system of definition of standards of care and practice can be modified as necessary to accommodate midwifery practice. Consumers have confidence in nurses and, based on this and experience elsewhere, would readily accept the nurse-midwife.

RECOMMENDATION (III): The nurse-midwife is best positioned for the necessary team relationships which must be developed and is the only model which should be introduced into our health care team in Manitoba.

RECOMMENDATION (IV): There is a role for the traditional birth attendant as specified in the activities defined in Appendix IV. There is no role for the lay midwife.

SCOPE OF PRACTICE

The Registered Nurses' Act(1981) of Manitoba defines "nursing practice" or "the practice of nursing" as

> *"representing oneself as a registered nurse while carrying out the practice of those functions which, directly or indirectly in collaboration with a client and with other health workers, have as their objective, promotion of health, prevention of illness, alleviation of suffering, restoration of health, and maximum development of health potential and without restricting the generality of the foregoing includes:*
>
> *(i) collecting data relating to the health status of an individual or group of individuals;*
> *(ii) interpreting data and identifying health problems;*
> *(iii) setting care goals;*
> *(iv) determining nursing approaches;*
> *(v) implementing care, supportive or restorative of life and well-being;*
> *(vi) implementing care relevant to medical treatment;*
> *(vii) assessing outcomes; and*
> *(viii) revising plans."*

A competent nurse can apply the necessary knowledge, judgement and skills for safe, effective nursing practice within professionally accepted standards (Sanford, 1989). The newly graduated nurse enters the profession able to:

(a) provide safe nursing care for individuals and families of all ages with common and predictable health problems directed toward alleviation of suffering and restoration of health; and
(b) have the potential to provide safe nursing care for individuals, families, groups and communities, with complex health problems

requiring specialized nursing care and which is concerned with promotion, prevention and working towards maximum development of health potential (RNABC, 1988).

The Registered Nurse provides care in collaboration with the recipient of nursing services. The nurse also collaborates with peers and other health care workers to manage and ensure the delivery of safe comprehensive nursing care. Nursing education is based on a holistic approach to the patient and family.

Although nurse-midwifery applies the same approach to the care of child bearing women, the practice of midwifery has a distinct body of knowledge. The nurse-midwife must be prepared to counsel and assist the pregnant woman when appropriate, manage care for her infant, and involve her family. The nurse-midwife must be an educator including, but not be limited to, issues related to nutrition, public health, newborn care, and family adjustment.

PRACTICE SETTINGS:

Although the intrapartum care is in hospitals or in free standing brithing centers, the nurse-midwife may also practice in clinics, health units and other health care settings including the home. The World Health Organization has stated:

> *"The nurse-midwife must be able to give necessary supervision, care and advise to women during pregnancy, labour and the postpartum period, to conduct deliveries on her <his> own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She <he> has an important task in health counselling and education, not only for the patients but also within the family and community. The work should involve antenatal education and preparation for parenthood, and extends to certain areas of gynaecology, family planning and child care." (cited in Report of the Task Force On The Implementation of Midwifery in Ontario, 1987, page 85).*

RECIPIENTS OF NURSE-MIDWIVES' SERVICES:

Nurse-midwives care for healthy pregnant women and their infants throughout the childbearing cycle. This care is provided within a family centred approach. Although the primary focus in on the healthy pregnant family, the nurse-midwife may also have a role in the delivery of care to women with pregnancy complications. The provision of prenatal care for single mothers, pregnant teenagers, and counselling of women at risk for low birth weight are two examples of appropriate contributions of nurse-midwives to the care of mothers with specific pregnancy risk or complications.

NURSE-MIDWIFERY MANAGEMENT:

Three aspects of nurse-midwife management have been described; primary management, collaborative management and referral/medical consultation. Primary management includes independent functions such as assessment, care planning, provision and evaluation of care. Collaborative management includes primary management and also physician consultation with joint nurse-midwife/physician management. Referral and medical consultation includes the identification of needs outside the scope of nurse-midwifery practice, selection of appropriate source of care and transfer of childbearing women to physician management as appropriate. (ACNM, 1985).

COMPONENTS OF NURSE-MIDWIFERY CARE:

Antepartum, intrapartum, postpartum, neonatal care, family planning, defined aspects of gynaecologic care and management of complications are all included in the nurse-midwifery scope of practice. Specific activities include:

1. Carrying out examinations necessary to identify and monitor normal pregnancy;
2. Providing prenatal education, support and counselling;
3. Assisting and caring for the mother during labour, including monitoring fetal well being;
4. Conducting spontaneous vaginal deliveries;
5. Recognizing signs of risk or abnormality and making appropriate referrals;
6. Examining and caring for the newborn infant, including neonatal resuscitation when necessary;
7. Caring for the mother in the postpartum period;
8. Providing support and education for parenting and infant care;
9. Offering advice and information on family planning
10. Counselling for illness prevention and health promotion (Ontario Task Force Report, 1987, page 86); and
11. Preparation and supervision of traditional birth attendants* (see definitions).

RECOMMENDATION (V): Nurse-midwifery education provides the knowledge and skills required to provide a wide range of services to women and their families in a collaborative holistic approach. Specific responsibilities must be defined to ensure the provision and evaluation of these services in all components of reproductive care; antenatal, intrapartum, postpartum, neonatal and designated gynaecologic needs.

QUALIFICATIONS

The Manitoba nurse-midwife should be a Registered Nurse with post-baccalaureate education who meets the stipulated articles in The Registered Nurses' Act and Regulations. This includes the requirements for Renew-

al of Registration. The nurse-midwife will have post-baccalaureate education in a recognized program of midwifery education.

The Committee recognizes that there may be many nurses not at the baccalaureate level who are interested in a career in midwifery and who have demonstrated competence. This group should be considered for entry to midwifery education and become eligible for certification.

RECOMMENDATION (VI): A group of Manitoba nurse-midwives hold professional qualifications in midwifery from other jurisdictions. An enabling mechanism should be developed to allow these qualified individuals to practice within the Manitoba system. This provision should be available for a specified period of time and allow for necessary upgrading and credentialing of academic knowledge and clinical midwifery skills. A mechanism must be established to allow for nurse-midwives with acceptable out of province qualifications to be eligible to practice in Manitoba.

STANDARDS OF COMPETENCY

The Manitoba Association of Registered Nurses (MARN) ensures that all practitioners meet acceptable standards of educational preparation, whether graduates of a Canadian nursing program or that of another country. The MARN is responsible for establishing and monitoring standards for basic and re-entry nursing education as well as standards of practice. Its disciplinary function ensures the public that the practicing Registered Nurse is accountable to a regulatory body.

During the phase of the development of speciality standards the nurse-midwife will function under the Generic MARN Standards of Nursing Practice. Specialty standards for midwifery practice should be developed by the MARN in collaboration with the Nurse Midwives Association of Manitoba within one year of implementing legal recognition.

LIABILITY PROTECTION

Active practicing members of the Manitoba Association of Registered Nurses (MARN) are covered for liability protection under the Canadian Nurses Protective Society (CNPS). The nurse-midwife, who is a member of the MARN, is automatically covered under CNPS and is subject to its rules and regulations. The Committee did not attempt to evaluate the effect of the introduction of midwifery on premiums either through CNPS or the Canadian Medical Protective Association. The Committee is of the opinion that costs will escalate and this matter must be evaluated within the developmental program. There must be full discussions with all principles to ensure comprehensive liability coverage.

RECOMMENDATION (VII): The Manitoba Association of Registered Nurses and the College of Physicians and Surgeons will be responsible for the delineation of entrance to practice qualifications, maintenance of

standards of practice, and the provision of liability protection for nurse-midwives.

RECOMMENDATION (VIII): The nature of coverage and cost impact of liability coverage must be discussed further with the relevant parties.

DOCTOR/MIDWIFE RELATIONS

The medical and nursing professions, including the nurse-midwife have a common goal of providing optimal care for childbearing families. They agree that providers of this care require a solid knowledge base, technical skills and good judgement as to whether, how and when to intervene in a specific situation.

The medical and nursing professions are accustomed to working together in providing care. The team approach requires that each member's role be defined, understood and respected. Physicians have been directors of the team but have depended upon skilled team members to provide "hands on" care, assist in specific tasks and collect data to support appropriate decisions. Care of child bearing families takes time and energy over prolonged and on occasion intense periods. A team approach ensures that a high standard of care will be available at all times through such intervals.

The implementation of nurse-midwifery will require some restructuring of current team relationships. These will vary with the institutional setting and the individual philosophy and clinical approach of physicians in a given area or institution.

It is understandable that the introduction of the nurse-midwife may be perceived by some physicians as an expansion in the role of nursing that threatens their own traditional role. However, the physician/nurse relationship is dynamic and healthy and may be expected to adjust to this new dimension as it has to many others.

A tertiary care setting alone may not be appropriate for most contemporary midwifery training. In Manitoba, the use of community and regional hospitals as training centres could provide both appropriate clinical material and a broader educational perspective of the needs of the community of child bearing families. Health care providers recognize the value of community, regional and northern settings for training resources and it will be important to share these resources wisely.

In many models of physician/nurse midwife interactions the physician is an obstetrician. This is particularly true of tertiary units. The role and the interrelation of the family physician and to some extent the pediatrician, to the midwife is less clear. Family physicians and nurse-midwives have a tradition of a holistic view of the childbearing family. This similarity should be exploited in a constructive and supportive way rather than a negative, competitive one. Canadian and other studies have compared the effectiveness of care of different professionals. One conclusion from these studies is that caring professionals can practice safely if they are well trained no matter what

their primary discipline (Buhler). All of these professional groups have an interest and special perspective which can be used to improve the quality of care.

RECOMMENDATION (IX): Many physicians have worked with or are interested in working with nurse-midwives in Canada. Various levels of participation by nurse-midwives, supervision by physicians and referral patterns between physicians and nurse-midwives and working relationships with other health care workers, have been proposed and variously accepted in other jurisdictions. Some examples of how these professionals might interact are presented in this paper for inclusion in the developmental program.

OBSTETRICIAN:

- available for consultation in high risk pregnancies for opinion, transfer of care and for specific technical skills;
- teaches and supervises family physicians and nurse-midwives in education programs;
- assist family physicians and nurse-midwives during practice;
- provides care to some healthy pregnant patients;
- refer some healthy patients to family physicians and/or nurse-midwives for care;
- refer some family, social and medical problems to family physicians and/or nurse-midwives; and
- participates in education programs for nurse-midwives.

FAMILY PHYSICIAN:

- cares for healthy pregnant patients and their families;
- shares care of patients with pregnancy complications with obstetricians;
- transfers care of some higher risk patients to obstetricians;
- refer some healthy pregnant patients to nurse-midwives (transfer or joint care depending on obstetric experience and practice);
- provides joint care with midwives particularly in rural, isolated or core area settings;
- accepts referral from both obstetricians and nurse-midwives for medical and family problems;
- available for consultation by nurse-midwives; and
- participates in education of nurse-midwives.

NURSE-MIDWIVES:

- cares for healthy patients in settings where physicians are available for assistance;
- refers patients with pregnancy complications to obstetricians (for transfer or combined care);
- refers some medical and obstetric problems to family physicians;

- accepts referrals from obstetricians and family physicians of healthy patients and those who require particular midwifery skills (adolescent, immigrant, native, those requesting nurse-midwives);
- provides newborn care independently or in collaboration with pediatricians and family physicians; and
- participates in education programs for nurses and physicians.

PEDIATRICIANS:

- participates in education of nurse-midwives;
- available for consultation by nurse-midwives; and
- accepts referrals of infants from nurse-midwives.

REGISTERED NURSES:

- works in collaboration with maternal-child nurses in all clinical settings;
- provides nurse to nurse referral to nurses working in community settings; and
- participates in education programs for registered nurses.

As available human resources for maternity and newborn services change over the years ahead, satisfaction of the various professionals involved will be sustained by such models of collaboration.

SPECIFIC ISSUES OF PEDIATRIC CARE BY MIDWIVES

A. Scope of Midwifery Pediatric Practice

1. Antenatal Guidance - A variety of issues relevant to the neonate should be discussed antenatally. These include:

   i) infant feeding practices and the promotion of breast feeding;
   ii) crib, car and home safety;
   iii) indications for seeking urgent care for the infant;
   iv) timing of immunizations;
   v) circumcision;
   vi) sibling issues, etc; and
   vii) normal development skills.

2. Newborn Care at Delivery - Assistance prior to delivery should be obtained if problems such as prematurity, fetal distress or meconium are present or anticipated. Nurse-midwives conducting deliveries must be trained and competent to provide neonatal resuscitation in accordance with national guidelines.

3. Continuing Newborn Care - Community based nurse-midwives, particularly in rural and remote regions would provide some ongoing infant care including immunizations. Problems would be referred as indicated to family physicians or pediatricians. In other locations neonates would be referred to primary care physicians. Nurse-midwives may fill or expand

on the current Public Health Nurse role for postpartum home visits. Regular postpartum home visits by nurse-midwives could be made available for selected families.

B. Relationship of Midwifery to Pediatric Standards and Physician Care

1. Standards - Midwives providing care to neonates and infants must be familiar with provincial and national guidelines and statements on infant care as published by the Canadian Medical Association, the Canadian Institute of Child Health, the Canadian Pediatric Society, and the College of Physicians and Surgeons of Manitoba. Nurse-midwives, as they become an established health profession in Manitoba, should be offered input into the formulation of such standards.

2. Referral - Physicians providing primary care to infants should be involved with care from birth. Physician care need not exclude continuing participation by nurse-midwives in aspects of infant care. Services available for families could be enhanced by continuing care by nurse-midwives. For nurse-midwives providing primary care to infants, a medical referral network would be required.

ECONOMIC IMPLICATIONS

Claims have been made that nurse-midwifery care is more cost effective than physician care based on the following:

1. physician education is more costly than nurse-midwifery education;
2. salaried nurse-midwives are paid less than physicians;
3. nurse-midwives rely less on expensive technology;
4. nurse-midwifery patients may have shorter lengths of stay in hospital (Ontario Task Force, 1987, Bergman, 1980, Lubic, 1975); and
5. nurse-midwifery patients may have lower rates of costly interventions.

Although there are a few isolated studies examining costs, there are no definitive studies substantiating the claim that the introduction of the nurse-midwife would result in reduced health costs. In the start-up phase the introduction of nurse-midwifery would represent an "add-on" expense and any cost saving would be associated with later changes in patterns of care. Because nurse-midwifery is not established in Canada, there are no studies upon which to base midwifery cost projections reliably for the Canadian or Manitoba health care environment.

Several related issues must be considered. The first is whether nurse-midwives should be salaried, paid directly by the recipients or reimbursed through a fee for service health insurance plan. In Manitoba the most appropriate approach would be to reimburse nurse-midwives through salaried positions. This would be consistent with the present practice of employing nurses as salaried health professionals, would facilitate maintenance of effective case loads, and facilitate issues of standards of care and liability insurance.

Other factors in the economic reckoning include: liability insurance for midwives, costs of providing nurse-midwifery education, and the costs of setting up and running a regulatory body. Nurses have traditionally paid lower malpractice premiums than physicians and have had relatively infrequent involvement in litigation but this is not likely to continue in the current Canadian medicolegal environment, in particular in areas pertaining to childbirth. Choosing a model of midwifery which incorporates the registered nurse holds promise for cost savings in education and administration of nurse-midwifery compared to the direct entry model.

RECOMMENDATION (X): In Manitoba midwifery as an insured service must be provided only by nurse-midwives who hold salaried positions. These salaries would be a direct "add-on" expense and must be accepted as such. The introduction of the nurse-midwife must have a parallel plan to evaluate potential areas of cost saving.

LEGISLATION

The Medical Act recognizes nurses acting within the scope of The Registered Nurses' Act of Manitoba (1981). Revisions in The Registered Nurses' Act, which reflect the scope of activity of the nurse-midwife, may be required to accommodate the scope of practice of midwifery. Hospital By-laws relevant to medical staff organization and clinical privileges would require revision to allow and issue clinical privileges in reproductive care areas to nurse-midwives. The nurse-midwife, although responsible generally to nursing, would also have definite responsibilities within the section of obstetrics.

FUTURE DIRECTION & RECOMMENDATIONS

During the preparation of this report the Committee was concerned about the absence of practical experience upon which to base firm conclusions. Accordingly, the following recommendations are designed for both the short term and also the future development of nurse-midwives in Manitoba.

Of the following, recommendation number one is the result of the overall deliberations of the Committee. Number two consists of specific observations and recommendations which are referenced by recommendations in the body of the report which bear the same number.

RECOMMENDATIONS:

1. Nurse-midwifery should be implemented in Manitoba. In order to facilitate this development, Manitoba Health should fund a developmental program during which the nurse-midwife will be employed. The Manitoba Association of Registered Nurses and the College of Physicians and Surgeons of Manitoba should be involved in the design and monitoring of the developmental program which must have:

   - clearly stated objectives;

- comply with the elements of recommendation two;
- include a concurrent evaluation system; and
- have a stated implementation target date.

2. The following recommendations and statements should be used to guide the implementation of the developmental project.

(I) The extension of authority for some medical acts to other members of the health team is necessary but will require careful implementation. Such extensions must be made with no loss of quality of outcome or service and mindful of issues relative to liability. The nurse-midwife must be prepared for and authorized to accept such responsibility.

(II) Need has been identified for midwifery care among families in selected or "at risk" groups (teenage, aboriginal, core area, and immigrant families). Accordingly, a rural or selected "at risk" setting should be one element of the developmental program.

(III) The nurse-midwife is best positioned for the necessary team relationships which must be developed and is the only model which should be introduced into our health care team in Manitoba.

(IV) There is a role for the traditional birth attendant as specified in the activities defined in Appendix IV. There is no role for the lay midwife.

(V) Nurse-midwifery education provides the knowledge and skills required to provide a wide range of services to women and their families in a collaborative holistic approach. Specific responsibilities must be defined to ensure the provision and evaluation of these services in all components of reproductive care: antenatal, intrapartum, postpartum, neonatal and designated gynaecologic needs.

(VI) A group of Manitoba nurse-midwives hold professional qualifications in midwifery from other jurisdictions. An enabling mechanism should be developed to allow these qualified individuals to practice within the Manitoba system. This provision should be available for a specified period of time and allow for necessary upgrading and credentialing of academic knowledge and clinical midwifery skills. A mechanism must be established to allow for nurse-midwives with acceptable out of province qualifications to be eligible to practice in Manitoba.

(VII) The Manitoba Association of Registered Nurses and College of Physicians and Surgeons should be charged with the responsibility for the delineation of entrance to practice qualifications, maintenance of standards of practice, and the provision of liability protection for nurse-midwives.

(VIII) The nature of coverage and cost impact of liability coverage must be discussed further with the relevant parties.

(IX) Many physicians have worked with or are interested in working with nurse-midwives in Canada. Various levels of participation by nurse-midwives, supervision by physicians and referral patterns between physicians and nurse-midwives and working relationships with other health care workers, have been proposed and variously accepted in other jurisdictions. Some examples of how these professionals might interact are presented in this paper for inclusion in the developmental program.

(X) In Manitoba midwifery as an insured service must be provided only by nurse-midwives who hold salaried positions. These salaries would be a direct "add-on" expense and must be accepted as such. The introduction of the nurse-midwife must have a parallel plan to evaluate potential areas of cost saving.

APPENDIX I

Home Births and Nurse-midwifery: Separate Issues

The qualification of the health care professional who provides comprehensive care for childbearing women, whether physician or nurse-midwife, is a very different issue from where delivery should take place. Unfortunately, the literature has often associated midwifery with home birth. The decision regarding the place of birth should be assessed separately from the introduction of nurse-midwifery.

Since the turn of the century there has been a sharp decline in the number of home births in North America and Britain. There have been arguments both for and against home births presented in the literature (Burnett, Jones, Rooks, Chen, Tyler & Miller, 1980; Cameron, Chase, & O'Neal, 1979; Goldman, 1988; Tew, 1984; Brown, 1987; Kloosterman, 1984, to name a few). Several professional organizations have opposed home birth based on the belief that the risks to both mother and infant are unacceptably high (Wallis, 1986). The statistics which have been presented in support of or in opposition to home birth, are problematic and may be misleading (Adamson, & Gar, 1980). For example, the demonstrated decline in the crude perinatal mortality rate which occurred at the same time in which home deliveries decreased is not necessarily due to place of birth alone. The rise in crude perinatal mortality for home births is due in part to increases in the proportion of unplanned births at home relative to those planned to occur there. Unplanned home births are often premature or precipitate (Campbell & Macfarlane, 1986), with associated negative consequences. Studies have often failed to account for the forces that motivate women to choose home delivery and risk status of the mother is often not considered in the analyses (Alberman, 1984, Alberman, 1986).

Some consumers in North America are objecting to what they perceive to be depersonalized care and are calling for alternatives. Some authors have suggested that such women choose home births because they want more control and a more personal atmosphere. In the United States, the cost of a hospital birth maybe prohibitive particularly to uninsured and lower income women, who are those most likely to need intervention. (Anderson, Bauwens & Warner, 1978). Although only a small proportion of women request home delivery, Zander (1984) has indicated that the home birth controversy is very significant because it reflects larger consumer concerns.

A place of birth should be chosen which results in the healthiest mothers and babies and the least number of complications. Those advocating home birth are asking for efforts to make home birth as safe as possible. (Anderson, 1986). Those supporting hospital delivery where necessary resources and personnel are available on short notice are encouraging a more homelike setting. Until randomized controlled trails are conducted and implications of the choices are more definitive, it is very difficult to advocate one site over the other with reliability or validity.

The formal acceptance of home birth in Manitoba would require development of policies and infrastructure to provide safe care for women choosing that option. The provision of adequate back up services would take careful planning and thought. It would be complicated by provincial demography, geography and climate, as well as the present medicolegal environment.

"Free standing" birthing centres (see definitions) have been developed as possible alternatives to home deliveries versus hospital in the United States in particular. Many of these are staffed by nurse-midwives. They deal with "low risk" normal deliveries, are usually affiliated with a hospital and provide for emergency referral to physicians/hospitals. Some medical personnel had a mixed reaction to these centres, governments saw them as a potential cost containment measure, and midwives saw them as an opportunity for autonomy and control. Consumers saw them as a form of family centered, noninterventionist maternity care (Annandale, 1989). Given appropriate placing and circumstances "free standing" birthing centres may become an appropriate alternative in Manitoba at some future date.

APPENDIX II

Lay Midwives

The introduction of another practitioner into the Manitoba health care system requires that the role of that practitioner be defined, understood and accepted, and that the consumer of the health services be guaranteed that the practitioner will provide safe and competent care. It is necessary to ensure that a regulatory body is responsible for standards of education and practice as well as the disciplinary process.

The Registered Nurse is a practitioner who is regulated under The Registered Nurses' Act. This legislation provides standards of nursing education, the definition of nursing practice and the regulatory process in the event of Complaints, Investigation and Discipline.

The lay midwife, as defined, does not provide the public with an acceptable standard of education and practice. Nor are there appropriate means of regulation. An unqualified birth attendant can make a valuable contribution to the child bearing family as a companion or traditional birth attendant.

APPENDIX III

Family Centered Care - Consumer Implications

In the past, the planning of obstetrical facilities, policies and procedures and education has not consistently taken into account the needs and wants of the pregnant woman and her family. Family centered care focuses on these elements and requires that they be addressed by modern institutions. (Canadian Guidelines for FCMC, 1987.)

Since the 1970's significant changes have occurred in most institutions that provide obstetrical care to Canadian families. Those changes have collectively been termed family centered care and are representative of a movement to change childbirth practices for the better.

Women are asking for a more personalized approach to childbirth and want more involvement in the decisions that affect them and their babies. While they continue to be concerned about the safe outcome of pregnancy they also feel that the experience of birth itself is important. The model of childbirth as an illness is also being challenged and being replaced by an emphasis on pregnancy and birth as normal life events. Often there is conflict between what women want from the childbirth experience and what their care givers and institutions are willing and able to provide.

Examples of consumer issues in this area include choice of place of birth, choice of whom will be present during delivery, avoidance of routine interventions, choice of delivery position and avoidance of separation of infant and family.

The majority of births are normal. Widespread use of obstetrical technology is both inappropriate for low risk birth and not without inherent risk (Enkin, 1989). Yet despite being seriously questioned many obstetrical routines and hospital traditions continue to persist (Hanvey, 1990).

While changes have occurred in many institutions that provide care for childbearing families these options are not accessible to all women particularly those in rural and remote parts of the country. Some argue, as well, that many such changes are superficial and have done little to shift the focus of control in childbirth from the care giver and the institutions to the women and her family (Hanvey, 1990, Romalis, 1985).

In 1986 the Canadian Medical Association produced a report which indicated high levels of satisfaction with obstetrical care among Canadian women (Roberts, Thompson, 1986). This report has been used to support the present system of childbirth care and deny the need for changes in birth options. It has also been offered as an indication of the lack of consumer support for the legalization of midwifery (Canadian Medical Association, 1987). The study has been criticized for methodological weaknesses which maked its use in support of such arguments questionable.

The practice of midwifery has been associated with the provision of many of the desired options in childbirth as well as a decreased use of technology and lower intervention rates. (Ontario Task Force, 1987 Rising, 1985)

The movement towards legalization of midwifery has been viewed by some as an example of how women have become empowered and have ultimately effected change in childbirth, (Hanvey, 1990) It cannot be assumed that the introduction of <nurse> midwives into the present system will make it truly family centered. However, the social forces behind the desire for women to have care by a <nurse> midwife will continue to effect needed change in childbirth options available to Canadian women in the future.

APPENDIX IV

Isolated Settings

The role of the nurse-midwife working in rural and remote communities is very different from their role as a member of an obstetric team working in a large urban hospital. The Northern Medical Unit is making this submission because of its conviction that the definition of nurse-midwifery by this Committee, the recommended content of any training program, and the definition of the relationships between nurse-midwives and other health professionals should take account of these differences.

The Northern Medical Unit supports the role of the nurse-midwife in northern health care for the following reasons:

i) its own direct and positive experience of the work of nurse-midwives in the northern context;
ii) the demand for nurse-midwives by people in northern communities;
iii) considerations of medical manpower in northern health care; and
iv) potential contributions of nurse-midwives to improving reproductive health care in northern communities.

1. The Northern Medical Unit has an unusual (in Canadian terms) background of experience in working with nurse-midwives. This has arisen because of the role the Unit has played in providing physicians to work in the reserves of northern Manitoba and in the Keewatin Region of the Northwest Territories under contract with the Medical Services Branch of Health and Welfare Canada, and the government of the Northwest Territories. Medical services had a tradition of hiring nurse-midwives, usually from overseas, to work in the nursing stations provided in these communities. Nurse-midwives were responsible throughout the 1970's for providing the bulk of prenatal care and also for doing low risk deliveries in the nursing stations.

   Few nurse-midwives now work in the north and medical policy has shifted towards the evacuation of all women to hospital for childbirth, regardless of their level of risk. Nevertheless, prenatal care is still provided at the nursing stations, although usually by Canadian nurses who, despite their other skills, are without the specialized training of the midwife. Although they no longer do low risk deliveries, these nurses must still deal with the high risk situation created when women go into labour while still in the community. (A recent review of the medical records for Inuit women from the Keewatin reported that labour started prior to their evacuation to hospital for between 15% to 18% of women.)

   The Northern Medical Unit has been sending family physicians to visit the nursing stations since the early 1970's. They worked closely with the nurse-midwives in the provision of prenatal care and were sometimes, but not always present when a woman delivered at a nursing station. The Northern Medical Unit is also an academic department and has sponsored a number of reviews of obstet-

rics care in the North. These reviews have been generally positive in their evaluation of the part played by nurse-midwives in this care.

2. The Northern Medical Unit is also familiar with the importance of the nurse-midwife as seen from the perspective of the communities in which they once worked. As one of the immediate representatives of the health care system in the north, the Northern Medical Unit has been the recipient of criticisms of people in northern communities directed against the policy of evacuating all women south for childbirth and the loss of the nurse-midwives. Women complain about living in hostels in unfamiliar cities, being lonely, about missing their families and being worried about their other children. Many women want a return to birthing in their own community attended by nurse-midwives. (In the study of births in the Keewatin, the mean number of days between a woman leaving her community and childbirth was 16.8 with a range of 0 to 85).

   Northern communities are also asking for care in childbirth which is more culturally sensitive and aware. Based on a model of childbirth used in a program in Northern Quebec, some have suggested a collaboration between formally trained nurse-midwives (preferably themselves northern women), the traditional elders, and women from the communities trained as birth attendants.

3. The Northern Medical Unit is very aware that many of the factors that increase the risks of pregnancy and childbirth among northern women are social and environmental and not susceptible to clinical intervention at the time of birth. A nurse-midwife living in a community and working closely with women from that community may be far more effective in changing some of the parameters of reproductive behavior, whether diet or smoking or the rate of teenage pregnancies.

4. Looking at the issues of midwifery from the perspective of medical personnel, the Northern Medical Unit is concerned lest questions raised about the place of the nurse-midwife within the urban health care system should distract attention from the very different manpower issues being faced not only in the north, but in rural areas generally.

   The Northern Medical Unit is acutely aware of the problems of maintaining physician services to northern communities, particularly in relation to prenatal and obstetric care. As family practitioners withdraw at an increasing rate from any involvement in obstetric care, it is becoming more and more difficult to recruit physicians who have an interest and training in this field. Obstetricians cannot be substituted for the role of the family practitioner. From a human resource perspective, their use in remote areas would not be appropriate, even if obstetricians were not difficult to attract into work with remote northern populations. Given these problems of medical staffing there is an obvious attraction to filling this gap through the services

of specially trained nurse-midwives. Equipped with the latest in communication technology, they can work closely with an obstetrician, but not under his <her> direct supervision. Nurse-midwives could provide not only prenatal care for low risk women, but could evaluate and refer the high risk pregnancy to an urban centre for specialist care.

The Unit recognized that providing a nurse-midwife to every community will not be feasible in the immediate future, given the inevitable delays arising from recruitment and training schedules. The development of a regional (multi-community) system is likely, however, and will foster small area regionalization. Nurse-midwives could have an important place in a new system for the delivery of health care in remote areas based on a tiered services model.

DEFINING THE ROLE OF THE NURSE-MIDWIFE:

The Northern Medical Unit hopes that the definition of the role of the nurse-midwife adopted by the Committee will be sufficiently broad to encompass her <his> potential role in northern communities. A definition adopted by the International Federation of Gynaecologists and Obstetricians in 1973 and now used by WHO aptly describes the scope of her <his> work:

"She <he> must be able to give the necessary supervision, care and advise to women during pregnancy, labour and the postpartum period, to conduct deliveries on her <his> own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She <he> has an important task in health counselling and education, not only for the patients but also within the family and community. The work should involve antenatal education and preparation for parenthood, and extends to certain areas of gynaecology, family planning and health care."

This definition focuses on the role of the nurse-midwife, but does not deal with the critical importance of integrating her <his> services with those of other health care providers. There is potential for conflict in the north as in the urban context, but its expression may be forestalled by the encouragement of collaborative decision making. It is critically important that the committee should define clearly the ways in which the nurse-midwife is to be integrated into the health care team.

SELECTION AND TRAINING:

The Northern Medical Unit is concerned that the interests and needs of northern aboriginal women should be considered in any recommendation made by the Committee relative to the selection and training of nurse-midwives. This should include exposing nurse-midwifery students to the conditions of working in the north, but also ensuring that access to

any nurse-midwifery training program is open to northern and aboriginal people. The role and influence of such people could be of critical value within their own communities and within the system of northern health care. The problems of recruiting Northerners into training programs for nurses are familiar. It is important that thought be given to making midwifery training easily accessible, both geographically and in terms of entrance qualifications. Insistence on a Bachelor of Nursing, for example, as a condition of admission will severely limit the opportunity for northern nurses to apply.

The Unit makes the following suggestions:

a. access to nurse midwifery training should be facilitated for persons from northern communities;

b. some components of the midwifery training program should be available via satellite links to northern centres providing nurse training;

c. students taking nurse midwifery training should spend part of their practicum in a northern nursing station supervised by a nurse-midwife with northern experience; and

d. the curriculum should include training in the skills needed by a midwife working in the north including the skills necessary to provide prenatal care and managing deliveries within the more limited technological scope of the nursing station.

APPENDIX V

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